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DISCLOSURE OF ADVERSE EVENTS: AN INTEGRAL AND NECESSARY PART OF THE TREATMENT?

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'*Informing a patient of what treatment has been given and what has taken place while doing so, whether or not there has been a catastrophe, is integrally and necessarily part of giving medical treatment to a person*'.[1]

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[1] *Breen v Williams* 1994, New South Wales Supreme Court, unreported, Bryson J, 10 October 1994.

I INTRODUCTION

An ordinary patient receiving negligent medical treatment may have little, if any, perception of an adverse event or negligence having affected his or her medical outcome. This is, perhaps, more evident where the patient was at the time affected by anaesthesia or sedation, or was a child or under a disability. Such a patient is in a different position to a person injured in a car accident, or at work, or in a public place. In the ordinary course of events, that person would at least be aware of the relationship between an incident and an injury, and so if not already cognisant of a negligent cause of injury, then at least would be aware of that possibility as warranting investigation.

An 'adverse event' is defined as 'an incident in which unintended harm resulted to a person receiving health care'.[2] Practical guidelines for the disclosure of adverse events to patients have been in place in Australia for some time. However, there has been no widely recognised ethical obligation or legal duty to disclose to a patient the medical practitioner's knowledge or suspicion of an adverse event caused by that practitioner (or indeed another practitioner), even in cases where the practitioner recognises that the event could be negligent.

II PRACTICAL GUIDELINES

The Australian Council for Safety and Quality in Health Care (ACSQHC) was established in January 2000 by the Australian Health Ministers to lead national efforts to improve the safety and quality of health care provision in Australia. In 2003 the ACSQHC obtained endorsement from the Australian Health Ministers of a National Open Disclosure Standard.

[2] Australian Council for Safety and Quality in Health Care, *Open Disclosure Standard* (2003) 6 citing Ross Wilson, WilliamRunciman, and Robert Gibberd, 'Quality in Health Care Study' (1995) 16(9) *Medical Journal of Australia* 458 <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/F87404B9B00D8E6CCA2571C60000F049/$File/OpenDisclosure_web.pdf> at 8 March 2007.

This document has no legal standing,[3] rather, it was put forward as a resource for those organisations seeking to implement open disclosure. Open disclosure is defined to refer to open communication when things go wrong in health care, the elements including an expression of regret, a factual explanation of what happened, consequences of the event; and steps being taken to manage the event and to prevent a recurrence.[4]

In relation to the practical implementation of the disclosure guidelines, it has been noted:

> …as long as stakeholders recognise and accept that the open disclosure process should not and is not intended to constitute a detailed forensic analysis of the event but is rather confined to the prompt and emphatic notification of the fact that things went wrong, coupled with an undertaking (where that can be given) to conduct and report back on relevant follow-up, many of the difficulties will be avoided.[5]

In July 2005 the Australian Health Ministers acknowledged the widespread acceptance of the ACSQHC's National Safety and Quality agenda and agreed to establish the Australian Commission on Safety and Quality in Health Care to facilitate the development and implementation of ACSQHC's initiatives, including the National Open Disclosure Standard. The Commission succeeded the ACSQHC as from 2006. Running in parallel in New South Wales is the work of the Clinical Excellence Commission.

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[3] As to the legal status of Australian Standards, Standards Australia states: 'Standards are not legal documents. But because of their convenience and the willingness of all parties to adopt them, many of them are actually called up in Federal or State legislation, and then become mandatory; however most are used voluntarily by people who value their expertise and common sense. They're practical and don't set impossible goals. They're based on sound industrial and scientific experience. And, because they're regularly revised, they also keep pace with new technologies.' See *Chicco v Corporation of the City of Woodville* (1990) Australian Torts Reports 81-028; *Giner v Public Trustee* (1991) 105 FLR 410; *Maynard v Rover Mowers Ltd* (2000) QCA 26. See generally Corrs Chambers Westgarth, *Open Disclosure Project: Legal Review* (2002) pt 9: Making compliance mandatory: the role and status of standards', 57–9 <www.nsh.nsw.gov.au/teachresearch/cpiu/CPIUwebdocs/FinalLR858178v1.pdf> at 27 March 2007.

[4] See Australian Council for Safety and Quality in Health Care, *National Open Disclosure Standard: Fact sheet* <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/3D5F114646CEF93DCA2571D5000BFEB7/$File/opendisclfact.pdf > at 27 March 2007.

[5] Corrs Chambers Westgarth, above n 3, pt 2.1.3: The Health Professionals, 7.

III ETHICAL OBLIGATIONS

The New South Wales Medical Board (NSWMB) obtained approval from the then Health Minister, Mr Morris Iemma, for a Code of Professional Conduct entitled '*Good Medical Practice*: *The Duties of a Doctor Registered in New South Wales*'[6] under s 99A of the *Medical Practice Act 1992* (NSW). Standard 2.5 contemplates disclosure of adverse events to patients in cases of serious harm. The standard is in the following terms:

> 2.5 … act immediately to put matters right, if it is possible, if a patient under your care has suffered serious harm, through misadventure or for any other reason. You should explain fully to the patient what has happened and the likely short and long-term effects. When appropriate, you should offer an apology. If the patient lacks the maturity to understand what has happened, you should explain the situation honestly to those with parental responsibility for the child. If the patient is cognitively impaired you should provide explanation to the patient's parent, guardian, carer or person responsible.

The New South Wales provisions are modelled on the *Good Medical Practice* guidelines developed in 1988 by the United Kingdom General Medical Council (GMC)[7] which state:[8]

> 22. If a patient under your care has suffered harm, through misadventure or for any other reason, you should act immediately to put matters right, if that is possible. You should explain fully to the patient what has happened and the likely long-and-short term effects. When appropriate you should offer an apology. If the patient is an adult who lacks capacity, the explanation should be given to a person with responsibility for the patient, or the patient's partner, close relative or a friend who has been involved in the

[6] New South Wales Medical Board, *Code of Professional Conduct: Duties of a doctor registered with the New South Wales Medical Board* (2005) <http://www.nswmb.org.au/index.pl?page=44> at 27 March 2007.

[7] The GMC was established under the *Medical Act of 1858* (UK). It has powers to protect, promote and maintain the health and safety of the public. The governing body, the Council, has 35 members: 19 are doctors elected by doctors on the register; 14 are members of the public appointed by the Privy Council; and two are academics appointed by the universities and medical royal colleges.

[8] General Medical Council *Good Medical Practice* London 1998. See [16–21]; See especially [17].

> care of the patient, unless you have reason to believe the patient would have objected to the disclosure. In the case of children the situation should be explained honestly to those with parental responsibility and to the child, if the child has the maturity to understand the issues. [9]

Most Australian State and Territory Medical Boards have adopted, or are in the process of adopting provisions in essentially the same terms as the NSWMB Code. For example, the Medical Board of the Northern Territory has adopted a set of *Good Medical Practice Guidelines*,[10] which are in essentially the same terms as the NSWMB provisions and in particular, patient disclosure is limited to cases of serious harm.[11] To the same effect is the Medical Board of Western Australia Policy document, '*The duties of a medical practitioner registered with the Medical Board of Western Australia*'[12], the Medical Council of Tasmania's '*Guide to Good Medical Practice*'.[13] The Medical Practioners Board of Victoria's '*Good Medical Practice*' is also in similar terms to the NSWMB Code.[14]

It should be noted that the Queensland provisions[15] contemplate a broader disclosure obligation, which, like the UK '*Good Medical Practice Guidelines*', is not limited to cases of serious harm, but extends to all harm. The Queensland guidelines provide, inter alia:

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[9] That statement remains in identical terms in the current 2001 edition of *Good Medical Practice:* General Medical Council *Good Medical Practice* (3rd ed) London May (2001) [22]; <http://www.gmc-uk.org/guidance/good_medical_practice/index.asp> at 27 March 2007.

[10] Effective 14 May 2004 (to be reviewed 23 January 2007) <http://www.nt.gov.au/health/org_supp/prof_boards/medical/Good%20Practice%20Medicine%20Guidelines.doc> at 27 March 2007.

[11] See: 2.5 (If Things Go Wrong and 2.9 (Your Duty To Protect All Patients).

[12] See 4.5 (If Things Go Wrong) and 4.9 (Your Duty to Protect all Patients) <http://www.wa.medicalboard.com.au/pdfs/DutiesOfADoctor.pdf> at 27 March 2007.

[13] See 2.5 (If Things Go Wrong) and 2.9 (Duty to protect all patients) <http://www.medicalcounciltas.com.au/pdfs/Guide%20to%20Good%20Medical%20Practice.pdf> at 27 March 2007.

[14] Medical Practitioners Board of Victoria, 'Good Medical Practice' <http://medicalboardvic.org.au/pdf/Good%20Medical%20Practice.pdf> at 27 March 2007. See especially, [2.5] (If things go wrong) which confines the patient disclosure obligation to cases of serious harm and [2.9] (Your duty to protect all patients).

[15] See <http://www.medicalboard.qld.gov.au/publications/Resource%20Pack/Good%20Medical%20Practice.pdf> at 27 March 2007.

> 2.5 (If things go wrong)
>
> 2.5.1 If a patient under your care has suffered or may suffer harm, through misadventure or for any other reason, you should act immediately to put matters right if that is possible. You should explain fully to the patient what has happened and the likely short and long-term effects. This explanation should be provided to those who have legal responsibilities for a patient when that situation arises. When appropriate, you should offer an apology.

By contrast, the Code of Ethics published by the Australian Medical Association (AMA)[16] makes no express reference to an ethical obligation to disclose adverse events to patients or others such as peer review bodies. This is so even though the AMA Code refers to the 1996 Canadian Medical Association Code of Ethics, which was subsequently updated in 2004 to provide that practitioners should 'Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient'.[17] The AMA Code does include, however, a requirement in its very first clause to 'Consider first the well-being of your patient',[18] an express requirement to 'Maintain accurate contemporaneous clinical records',[19] and the exhortation to 'Make sure that you do not exploit your patient for any reason'.[20] Furthermore there is also a requirement to 'Report suspected unethical or unprofessional conduct by a colleague to the appropriate peer review body'.[21] It may be that clinical incompetence will be regarded as unprofessional conduct[22] so that an obligation to report to a peer review body may arise. In New South Wales, s 36(1)(a) of the *Medical Practice Act 1992* (NSW) provides that for the purposes of the Act, unsatisfactory professional conduct of a registered medical practitioner includes 'any conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a

[16] References are to the version released on 3 May 2004 <http://www.ama.com.au/web.nsf/doc/WEEN-6VL8CP> at 27 March 2007.
[17] See [14] <www.cma.ca/index.cfm/ci_id/2419/la_id/1.htm> at 27 March 2007.
[18] Cl 1.1a.
[19] Cl 1.1f.
[20] Cl 1.1h.
[21] Cl 2.1d.
[22] See, eg, *Medical Practitioners Board of Victoria Re: Dr Ronald Leopold Graydon van Houten* [2002] MPBV 19.

practitioner of an equivalent level of training or experience.' It may also be that failure to comply with the open disclosure standard, especially where patients have been deliberately misled as to the events which occurred during treatment, will amount to professional misconduct.[23]

IV LEGAL DUTIES

A *Statutory Duties*

1 *United States*

In the United States, the American Medical Association publishes a set of principles of medical ethics, which include the following statement:[24]

> It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care. Ethical responsibility includes informing patients of changes in their diagnoses resulting from retrospective review of test results or any other information. This obligation holds even though the patient's medical treatment or therapeutic options may not be altered by the new information. Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient.[25]

Several states of the United States of America have enshrined this ethical principle in legislation. For example, the *New Jersey Patient Safety Act* ('*NJSA*')[26] requires every health care facility to inform every patient affected by a 'serious preventable adverse

[23] *Skidmore v Dartford & Gravesham* [2003] UKHL 27.
[24] See E-8.12: Patient Information.
[25] The AMA (USA) publishes its policies on the internet, see <www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-8.12.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-7.05.HTM&nxt_pol=policyfiles/HnE/E-8.01.HTM&> at 27 March 2007.
[26] See <http://www.lindabury.com/resources/Patient%20Safety%20Act.pdf> at 27 March 2007.

event or adverse event specifically related to an allergic reaction no later than the end of the episode of care, or if discovery occurs after the end of the episode of care, in a timely fashion (author's emphasis).' In cases where it is determined that disclosure 'would seriously and adversely affect the patient's health', the notice can be provided to a family member, however, 'if an adult patient is not informed of a serious preventable adverse event or adverse event specifically related to an allergic reaction, the facility shall assure that the medical record includes a statement that provides the reason for not informing the patient'.[27]

Similarly, in Pennsylvania, s 308 of the *Medical Care Availability and Reduction of Error (Mcare) Act (2002)*, Act 13 of 2002, imposes a statutory duty on health care workers[28] to report serious events or incidents[29] and an obligation on medical facilities[30] to notify the patient in writing of a serious event within 7 days.[31]

2 *Australia*

Although many Australian jurisdictions have now enacted legislation to give medical practitioners some protection from legal suit when apologising for or expressing

[27] *NJSA* 26:2H-12.25(3)(d); *NJSA* 26:2H-12.23 et seq.
[28] 'Health care worker' is defined in s 302 to mean 'An employee, independent contractor, licencee or other individual authorised to provide services in a medical facility'.
[29] Section 308(a).
[30] 'Medical facility' is defined in s 302 to mean 'An ambulatory surgical facility, birth center or hospital'.
[31] Section 308(b). Similar provisions exist in Nevada (*Revised Statutes title 40* s 439.835 (2003)) and Florida (*Revised Statutes title 29* s 395.1051 (2003)): See the discussion in Carol Liebman and Chris Hyman, 'A Mediation skills model to manage disclosure of errors and adverse events to patients' (2004) 23(4) *Health Affairs* 22. New legislation is expected to take effect in Illinois from 1 January 2008, which will that will require hospitals and surgery centres in the State to publicly admit if they commit any of 24 types of 'never events' - 'inexcusable hospital foul-ups that should never occur but happen all too often'. Such events include operating on the wrong limb, leaving a surgical sponge behind, using the wrong blood type or causing a patient death with a medication overdose.

regret regarding an adverse event or outcome,[32] there is no corresponding express statutory duty[33] to give an expression of regret, a factual explanation of what happened, information regarding the consequences of the event; or an outline of steps being taken to manage the event and prevent a recurrence, as envisaged by the ACSQHC.[34]

While the purpose of such provisions may have been to facilitate and encourage the making of apologies without fear of legal exposure,[35] there is no irreconcilable tension between an apology and a duty to disclose adverse events. The importance of both open disclosure and an apology, where appropriate, as a way of improving communication and trust between patients and health care providers — and ultimately avoiding unnecessary litigation — has been identified by Dr Albert Wu of the John Hopkins University School of Medicine in the following comment:

> In over 25 years of representing both physicians and patients, it became apparent that a large percentage of patient dissatisfaction was generated by physician attitude and denial, rather than the negligence itself. In fact, my experience has been that close to half of malpractice cases could have been avoided through disclosure or apology but instead were relegated to litigation. What the majority of patients really wanted was simply an honest explanation of what happened, and if appropriate, an

[32] See *Civil Liability Act 2002* (NSW), ss 68-9; *Civil Liability Act 2003* (Qld), ss 68–72; *Civil Liability Act 2002* (WA), ss 5AF–5AH; *Civil Liability Act 2002* (Tas), s 7; *Civil Law (Wrongs Act) 2002* (ACT), ss 12–14; *Personal Injuries (Liabilities and Damages) Act 2003* (NT), ss 11–13. Compare with *Wrongs Act 1958* (Vic), s 14I–J (not admission but still admissible); *Civil Liability Act 1936* (SA), s 75 (not admission only). For a discussion see Prue Vines, 'Apologising to avoid liability: cynical civility or practical morality?' (2005) 27(3) *Sydney Law Review* 483. The New Jersey *Patient Safety Act* provides an interesting contrast, in that the sections giving protection do not apply where the health professional has 'displayed recklessness, gross negligence or willful misconduct, or in which there is evidence, based on other similar cases known to the facility, of a pattern of significant substandard performance that resulted in serious preventable adverse events': *NJSA* 26: 2H-12.25(3)(f).

[33] Liability may arise for nondisclosure on the basis that silence may amount to a misrepresentation under the *Trade Practices Act 1974* (Cth) or State Fair Trading Acts.

[34] See <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/3D5F114646CEF93DCA2571D5000BFEB7/$File/opendisclfact.pdf> at 27 March 2007.

[35] Villa has observed that the NSW Second Reading speech for the *Civil Liability Act 2002* (NSW) explained the rationale for the reforms as follows: Injured people often simply want an explanation and an apology for what happened to them … This is therefore an important change that is likely to see far fewer cases ending up in court: Dominic Villa, *Civil Liability Act 2002 (NSW)* (2004), 293–4.

apology. Unfortunately, when they were not only offered neither but were rejected as well, they felt doubly wronged and then sought legal counsel.[36]

B *Common Law Duties*

1 *English Authority*

There has been some English judicial comment on a legal duty to disclose adverse events. In *Naylor v Preston Area Health Authority*,[37] Sir John Donaldson, MR, considered that a duty of candid disclosure ought to be recognised as an aspect of the general tortious duty of care, and as an implied contractual term. Such an obligation is founded on notions of the protection of bodily integrity, individual autonomy and the right to self-determination. Sir John Donaldson said:

> I personally think that in professional negligence cases, and in particular in medical negligence cases, there is a duty of candour resting on the professional man. This is recognised by the legal professions in their ethical rules requiring their members to refer the client to other advisers, if it appears that the client has a valid claim for negligence.
>
> This also appears to be recognised by the Medical Defence Union, whose view is that 'the patient is entitled to a prompt, sympathetic and above all truthful account of what has occurred' (Journal of the MDU (1986) vol 2, no 2, p 2). It was also the view (admittedly obiter) of myself and Mustill LJ, as expressed in our judgment in *Lee v South West Thames Regional Health Authority [1985]* 2 All ER 385 at 389–390 [1985] 1 WLR 845 at 850.
>
> In this context I was disturbed to be told during the argument of the present appeals that the view was held in some quarters that whilst the duty of candid disclosure, to which we were referred, might give rise to a contractual implied term and so benefit private fee-paying patients, it did not translate into a legal or equitable right for the benefit of national health service patients. This I would entirely repudiate. In my judgment, still

[36] Albert Wu, 'Handling hospital errors: is disclosure the best defence?' (1999) 131(12) *Annals of Internal Medicine* 970, cited in Corrs Chambers Westgarth, above n 3, pt 3.6 Open disclosure: will it increase or decrease litigation?, 24.
[37] (1987) 2 All ER 353.

admittedly and regretfully obiter, it is but one aspect of the general duty of care, arising out of the patient/medical practitioner or hospital authority relationship and gives rise to rights both in contract and in tort.[38]

2 *Australian Authority*

Naylor[39] was considered by Justice Bryson in the Supreme Court of New South Wales first instance judgment in *Breen v Williams*,[40] which of course ultimately found its way to the High Court.[41] By way of obiter, His Honour said:

> In *Lee v South West Thames Regional Health Authority* [1985] 1 WLR 845 at 850, 851 Donaldson MR and Mustill J made obiter observations supporting a duty of a hospital to report what had happened in an operation in which the patient had suffered catastrophically. Donaldson MR referred to these observations in Naylor v Preston Area Health Authority [1987] 1 WLR 958 at 967 and confirmed them. These observations were based on the consideration that there may be an implied contractual duty to inform the patient what treatment he in fact received. I would not doubt that there is, as communication with the patient, both before and after treatment, of the diagnosis, advice about what treatment is proposed, and of a report of what treatment has taken place are all integral and essential parts of treatment. They are essential where the patient is conscious and has the capacity to participate in them, because of the nature of the patient as a person with a right to give or withhold consent to an intervention in his body by another person.
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> Informing a patient of what treatment has been given and what has taken place while doing so, whether or not there has been a catastrophe, is integrally and necessarily part of giving medical treatment to a person. One cannot stick a needle into a person and walk away wordless, as one would with a horse. I would respectfully say that Donaldson MR's observations appear to me to be correct and plainly so, but that they

[38] Ibid 360. Such a duty has also been recognised in Canada: see *Stamos v Davies* (1985) 21 DLR (4th) 507 (Ont HC); *Gerula v Flores* (1995) 126 DLR 507. For a discussion of the US case law, see Joan Vogel and Richard Delgado, 'To tell the truth: physicians' duty to disclose medical mistakes' (1980) 29 *UCLA Law Review* 52; Theodore Le Blang and Jane King, 'Tort liability for nondisclosure: the physician's legal obligations to disclose patient illness and injury' (1984–1985) 89 *Dickinson Law Review*, 26–30, 35–45

[39] Ibid 37.

[40] 1994, New South Wales Supreme Court, unreported, Bryson J, 10 October 1994.

[41] (1996) 186 CLR 71.

> relate to treatment and not access to medical records, or to the provision of information after everything which could be regarded as treatment has concluded.

There may be practical implications under the common law for nondisclosure of adverse events for patients in some circumstances. Nondisclosure may mean that the patient loses the opportunity to obtain remedial treatment. For example, in *Wighton v Arnot*[42] (*Wighton*) investigation and disclosure of the suspected adverse event would have made a difference to the patient's long term prognosis, but it was too late for a successful repair of the severed nerve by the time the patient discovered what had happened.[43] In that case it was held that a duty to disclose arose in circumstances where the knowledge was of relevance to the patient's medical outcome and was a necessary part of reasonable after care. The duty was held to extend to an obligation to make investigations where there is a suspicion of an adverse outcome. Justice Studdert said: 'What the exercise of due care required of the defendant was that he take reasonable steps to determine whether it was the accessory nerve which had been severed, and that he alert the plaintiff as to what had occurred'.[44]

As to suspicion, His Honour stated: 'Plainly, it was the defendant's duty to seek to determine whether his suspicion at the time of surgery was well founded'.[45]

Justice Studdert then went on to address the patient's right where there was such a suspicion of adverse events:

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[42] [2005] NSWSC 637.

[43] 'No further surgery has been undergone by the plaintiff, and I am satisfied that the opportunity for a successful repair was lost before the plaintiff discovered that her spinal accessory nerve had been severed in November 1999', [33] (Studdert J).

[44] Above n 42, [38]: Such a duty has been recognised in the US; see, for example, *Mink v University of Chicago* 460 F Supp 713 (ND Ill 1978): 'When the University hospital became aware, or should have become aware, of facts which would induce a reasonable physician under the same circumstances to warn patients of the risks involved in treatment, a duty to notify arose. The fact the knowledge of the risk was obtained after the patient was treated does not alter the obligation. If the defendant fails to notify the patient when the risk becomes known, he has breached this duty' (Studdert J).

[45] Above n 42, [39] (Studdert J).

> Further, it seems to me that at the time of discharge, even if by that time the defendant did not know it was the accessory nerve he had severed, the plaintiff had a right to know, and the defendant had a duty to inform her, that he had severed a nerve which he suspected was the accessory nerve.[46]

In *Wighton*[47] there was no finding that the defendant doctor had been negligent in the performance of the operation, or in severing the nerve. Justice Studdert summarised the plaintiff's case as being that the defendant severed the right spinal accessory nerve at the third of the surgical procedures undertaken, and that his treatment of the plaintiff thereafter was negligent in that:

- he failed to inform the plaintiff of his suspicion that he had severed that nerve;[48]
- he failed by appropriate examination to confirm that he had severed the nerve; and
- he failed to refer the plaintiff to an appropriate specialist for timely remedial surgery.

It seems, therefore, that the doctor would not have been found liable in negligence had he disclosed the adverse event to the patient.[49]

Although it has been suggested that therapeutic privilege may be a defence to nondisclosure of adverse outcomes,[50] this was not accepted in *Wighton*[51]. Justice Studdert said:

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[46] Ibid [64] (Studdert J).
[47] [2005] NSWSC 637.
[48] Above n 42 at [71-72]: It is possible that disclosure to the patient's general practitioner may have been sufficient (Studdert J).
[49] Above n 42, [36]: 'The plaintiff does not contend that the defendant was negligent in severing the nerve during the course of the operation. Nor is it contended that the defendant should have repaired the nerve during the surgery on 10 November' (Studdert J). See also [37-38] and the expert evidence at [65-67].
[50] See Le Blang and King, above n 38, 45.
[51] [2005] NSWSC 637.

> Dr Arnot said that he did not tell the plaintiff in hospital about the severance of the nerve because of her emotional state and because it was only a possibility that he had severed this nerve, and that possibility he considered to be 'probably wrong' because of his examination following surgery (T 476). Acceptance of the doctor's explanation for not alerting the plaintiff to what occurred depends upon acceptance that the shrug test was performed. Since I am not persuaded that it was, I do not find the defendant's explanation for not telling the plaintiff about the division of the nerve to be an acceptable explanation.[52]

In *Wighton*[53] as the expert evidence established that the usual practice would have been to disclose and investigate the suspected adverse event, and provide an opportunity for remedial surgery if necessary, the claim in negligence was made out.[54] It would also seem that the recent ethical guidelines relating to disclosure of adverse events to patients would be evidence of widely accepted competent professional practice in Australia for the purposes of s 5O *Civil Liability Act 2002* (NSW). Alternatively, given that the AMA has not adopted an express ethical obligation to disclose adverse events to patients, if evidence was led that nondisclosure was widely accepted in Australia by peer professional opinion as competent professional practice, given the NSWMB and corresponding ethical guidelines in other jurisdictions, it could be argued under sub-s (3) that there were differing peer professional opinions widely accepted in Australia which required such disclosure. In any event, there may be scope for the court to intervene under sub-s (2) in cases where peer professional opinion which considered that nondisclosure was led as evidence of the appropriate standard and declare such peer professional opinion to be 'irrational'. However, given s 5P, it may be that s 5O does not apply to cases where a breach of duty to disclose error is alleged. Section 5P provides that 'This Division does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in respect of the risk of death of or injury to a person associated with the provision by a professional of a professional service'.[55] If this is the case the

[52] Above n 42, [69] (Studdert J).
[53] [2005] NSWSC 637.
[54] See the expert evidence of Dr McKenzie at [65–67].
[55] As to ss 5O, 5P see generally Villa, above n 35, 88-101.

law as stated in *Rogers v Whitaker*[56] will apply to cases relating to failure to disclose medical error.[57]

V CONCLUSIONS

Honesty and trust are central to the health care professional/patient and health care institution/patient relationship, and health care professionals and institutions want to do 'the right thing' by their patients: 'Honest, effective and open communication is the foundation of the relationship between clinicians and patients. Telling the truth is always the right thing to do. Concealing the truth is wrong'.[58]

Although 'concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient',[59] it would seem that there is no evidence that open disclosure will necessarily lead to increased litigation. In relation to the question as to whether open disclosure increases or decreases litigation, the ACSQHC has commented:

> Adhering to the principles of the Open Disclosure Standard may result in an increase in legal claims. We know, however, that many health care errors do not become the subject of litigation and, unless the harm suffered by the patient is serious, legal action is unlikely to be taken. It is possible that open disclosure may assist patients who have suffered an adverse event to make a claim by providing them with the necessary information and understanding on which to base a claim. However, evidence suggests that following the principles of open disclosure may actually reduce a patient's desire to pursue legal action.[60]

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[56] (1992) 175 CLR 479.
[57] Ibid 409 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).
[58] William Barron and Mark G Kuczewski, 'Unanticipated Harm to Patients: Deciding When to Disclose Outcomes' (2003) 29(10) *Joint Commission Journal on Quality and Safety* 551, 552
[59] Above n 24; See also AMA, above n 25.
[60] See <http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/6A2AB719D72945A4CA2571C5001E5610/$File/opendisclfact.pdf> at 27 March 2007; See generally Corrs Chambers Westgarth, above n 3; See also Le Blang and King, above n 38, 45.

Practical guidelines to assist those who wish to implement open disclosure were developed by the ACSQHC in 2003. There are sound ethical reasons for promoting open disclosure as a means to enhance the trust between patient and health care professional, which has been recognised in recent ethical pronouncements of the various state and territory medical boards, though not yet by the Australian Medical Association.

In Australia, despite statutory protection for apologies, there is no statutory duty to disclose adverse events to patients, unlike in the United States. However, judicial statements in England and Australia suggest some support for a general duty to promptly disclose, certainly in a clear case, the fact of an adverse event and the possibility of any negligent aspect to the treatment, as an integral and necessary part of treatment and clear recognition where the patient suffers harm through the breach. In any event, it would seem that compliance or otherwise with the new ethical guidelines as to disclosure will now be a relevant consideration as to whether a practitioner has acted in accordance with widely accepted competent professional practice.